GUARDIAN®

The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

GG-013500
Enrollment Form
For Non-Medical Coverages

☒ Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

☐ Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

☐ Norwell Regional Office
P.O. Box 9121
Norwell, MA 02061-9121

☐ Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Planholder Name (Company Name)	Group Plan No.	Division	Class
City of West Lafayette	319018		

Planholder Street Address	City	State	Zip
609 West Navajo	West Lafayette	IN	47906

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION

CHANGE: ☐ ADD DEPENDENT(S) ☐ TERMINATE A FAMILY MEMBER ☐ ADDRESS ☐ NAME ☐ DELETE COVERAGE

DATE OF CHANGE ___/___/___ **REASON FOR CHANGE** _____

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Sex	Birthdate	Employee's Social Security #
Employee:	☐ M ☐ F		
Spouse:	☐ M ☐ F		Date of Marriage / /
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No

(1) Are any dependent children adopted? ☐ Yes ☐ No If "yes", indicate name and date of placement:
(2) Have you included stepchildren? ☐ Yes ☐ No If "yes", indicate name(s):
(3) Are they dependent on you for support and maintenance? ☐ Yes ☐ No

Date of Full Time Employment	Hrs. Worked / Week	Annual Salary	Occupation /Job Title
		$	

Employee's Street Address	City

State	Zip	Business Phone #	Home Phone #

DENTAL

☐ **Employee****
☐ **Employee & Spouse*****
☐ **Employee & Child(ren)*****
☐ **Employee, Spouse & Child(ren)*****

☐ **I decline coverage.** I understand if I elect coverage at a later date, late entrant penalties will apply. **

** If declining coverage, are you covered under another dental plan? ☐ Yes ☐ No *** If declining dependent coverage, are your dependents covered under another dental plan? ☐ Yes ☐ No

VISION

☐ **Employee****
☐ **Employee & Spouse*****
☐ **Employee & Child(ren)*****
☐ **Employee, Spouse & Child(ren)*****

☐ **I decline coverage.** I understand if I elect coverage at a later date, late entrant penalties will apply. **

** If declining coverage, are you covered under another dental plan? ☐ Yes ☐ No *** If declining dependent coverage, are your dependents covered under another dental plan? ☐ Yes ☐ No

DECLINATION OF COVERAGE:

* If I have waived the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.
- I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.
- I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.
- The information provided above is true and correct to the best of my knowledge.
- Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

X SIGNATURE OF EMPLOYEE	DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN